costs for each cost category from the midpoint of the period from which the costs were derived to the end of that period. (1-1-82)

b. The percentage change for each cost category in the market basket will be computed for the period beginning at the end of the period from which the per diem costs were derived and ending at the beginning of the period for which the reimbursement and the limitation of these costs is being calculated. These percentages will then be used to project forward the allowable per diem costs for each cost category, as determined in Subsection 254.10.a. from the end of the period from which they were derived to the beginning of the period for which the reimbursement and the limitation is being determined. (12-31-91)

c. The percentage change for each cost category in the market basket will be computed for the beginning to the end of the period for which the reimbursement and the limitation is being computed. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward the allowable per diem costs as determined in Subsection 254.10.b. from the beginning to the midpoint of the period for which the reimbursement and the limitation is being computed. (12-31-91)

09. Cost Ranking. Projected per diem costs as determined by Subsection 254.10 and subject to the percentile cap will be ranked from highest to lowest within each class of providers. Costs for providers will be grouped in classes according to the type of provider with the classes being Freestanding Nursing Facilities, Hospital Based Facilities, and ICF/MR. (12-31-91)

a. The standard deviation of the range will be computed based on the available data points being considered the total population of data points. (1-1-82)

b. The standard deviation figure will then be used to determine the percentile cap in accordance with the Idaho Code as follows:

If Two Times the Standard Deviation is	Then the Percentile Cap Will be
$2.99 or less	100%ile
$3.00 to $5.99	90%ile
$6.00 to $11.99	80%ile
$12.00 or greater	75%ile

(1-1-82)

c. The percentile cap will be computed based on the assumption that the range of costs is a statistically normal distribution unless the cap is to be at the one hundred (100) percentile. In that case, the highest cost in the range will become the percentile cap. (1-1-82)

d. The percentile cap for each facility's fiscal year following January 1, 1982, will be computed prior to the beginning of that fiscal year in accordance with the Idaho Code. For those facilities with a fiscal year ending on a date other than December 31, the first percentile cap will be computed for the period beginning January 1, 1981, and ending on their fiscal year end date. (1-1-82)

e. The percentile cap will be determined and set for each facility's upcoming fiscal year prior to that year and it will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical type errors, these errors will be corrected and the percentile cap adjusted to what it would compute to be using the corrected figures. (1-1-82)

f. Reimbursement of costs in this cost center will be limited to the percentile cap unless the provider can demonstrate to the Department of Health and Welfare that his facility was operated efficiently during the cost reporting period and that the costs incurred in excess of the percentile cap were beyond his control. In such case, costs in excess of the cap will be allowed to the extent that they are justified by this process. This is intended to allow the Department to determine if a facility was operated efficiently, in whole or in part, based on a demonstration of efficiency by the facility or another party. The Department can grant an exception to all or part of a percentile cap disallowance to the extent that there is a reasonable and prudent reason for the higher costs. (1-1-82)

g. Facilities which for the first time offer patient care services in the hospital-based facilities class on or after April 1, 1985, shall be subject to the same limitation on nonproperty nonutility reimbursement as is applied to the freestanding nursing facilities class with the same fiscal year as the hospital-based provider. The efficiency increment for such facilities shall be computed based on the fraction applicable to the freestanding nursing facilities class. Cost reports for such facilities shall be included in the hospital-based facilities class. (9-28-90)

255. EFFICIENCY INCREMENT.

A nursing facility efficiency increment will be included as a component of the total reimbursement if the allowable per diem costs incurred by the nursing facility provider for those cost categories subject to the percentile cap addressed in Section 254, are less than percentile cap for the class in which the facility belongs. (10-1-96)T

01. Computing Efficiency Increment. The efficiency increment will be computed by subtracting the actual allowable per diem costs incurred by the provider from the applicable percentile cap and multiplying the resultant figure by the fraction applicable to the cost center according to the following table: (1-1-82)

EFFICIENCY INCREMENT	
Percentile Cap Applicable to The Class of Facilities	**Fraction to be Used in Determining the Efficiency Increment**
100%ile	One-half (1/2)
90%ile	One-third (1/3)
80%ile	One-fourth (1/4)
75%ile	One-sixth (1/6)

02. Allowable Increment. The allowable increment cannot exceed one dollar and fifty cents ($1.50) per Medicaid patient-day. (1-1-82)

03. Determining Reimbursement. Total reimbursement determined by adding amounts determined allowable in accordance with Sections 252, 253, 254, and 255, shall not exceed the

provider's usual and customary charges for these services as computed in accordance with this chapter and HIM-15. In computing patient days for the purpose of determining per diem costs, in those cases where the Medicaid Program or the patient is making payment for holding a bed in the facility, the patient will not be considered to be discharged and thus those days will be counted in the total (treatment of bed hold days or leave of absence days are as addressed in Appendix C). (12-31-91)

256. DEFINITIONS. (7-1-93)

01. Lower of Cost or Charges. In addition to 42 CFR Part 447, the Title XIX Medical Assistance Manual (MSA) PRG 1, Part 6-170-20B states that on cost related basis of reimbursement "... the limit on payments for extended care facilities (ECF's) under Title XVIII shall not exceed ...". These limits are determined on an individual facility basis for comparable service. Supplement 5 of the 1972 amendments to the Providers Reimbursement Manual (SSA HIM-15) states "regulations based on the 1972 amendments (as revised by section 16 of P.L. 93-233) state that for services rendered in cost reporting periods beginning after December 31, 1973, payment to providers (other than public providers furnishing such services free of charge or at nominal charges to the public shall be the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge shall be reimbursed fair compensation which is the same as reasonable cost." (1-16-80)

02. Customary Charges. Customary charges are the regular rates for various services which are recorded for Medicare beneficiaries and charges to patients liable for such charges. Those charges are to be adjusted downward, however, where the provider does not impose such charges on most patients liable for payment on a charge basis or, fails to make reasonable collection efforts, the reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt (see Chapter 3, Sections 310 and 312, HIM-15). (1-16-80)

03. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (1-16-80)

04. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. The result of this is that the Title XIX rate may not exceed the Title XVIII rate, less ancillary charges or charges to third parties (i.e. general public) for comparable services. (1-16-80)

a. Assuming that the Title XVIII Part A rate is ten dollars ($10) per patient day (not including ancillaries), customary charges are fifteen dollars ($15) per patient day. (12-31-91)

b. In this case the customary charges are in excess of the potential rate so they are not a limiting factor. However, the Title XVIII Part A rate is less for equivalent services. Therefore, the interim reimbursement rate will be at the ICF/SNF rate of ten dollars ($10) per patient day. (12-31-91)

Idaho State Code extractions including references in Idaho State Plan

Provisions in this supplement are only applicable to the Idaho State Plan to the extent that such provisions are directly related to references in the plan to these provisions. In the event of any conflict, difference of definition, ambiguity, discrepancy, or dispute arising from provisions in this appendix, the provisions of this appendix are subordinate to state plan provisions not in this supplement as determined by the Department. Furthermore, any references to laws, rules, or documents which are exclusive to this supplement (which are not in Attachment 4.19-D of the State Plan) are to be deemed extraneous to the plan.

TITLE 56
PUBLIC ASSISTANCE AND WELFARE
CHAPTER 1
PAYMENT FOR SKILLED AND
INTERMEDIATE SERVICES

56-101. DEFINITIONS. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter and shall have the following meanings

(1) "Appraisal" means the method of determining the value of the property as determined by an appraisal conducted by a member of the appraisal institute (MAI), or successor organization. The appraisal must specifically identify the values of land, building, equipment, and goodwill.

(2) "Assets" means economic resources of the contractor, recognized and measured in conformity with generally accepted accounting principles.

(3) "Bed-weighted median" is determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per them costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median.

(4) "Case mix index" is a numeric score assigned to each facility resident, based on the resident's physical and mental condition, which projects the amount of relative resources needed to provide care to the resident.

(5) "Depreciation" means the systematic distribution of the cost or other tangible assets, less salvage, over the estimated useful life of the assets.

(6) "Direct care costs" consists of the following costs directly assigned to the nursing facility or allocated to the nursing facility through medicare cost finding principles

(a) Direct nursing salaries which include the salaries of registered nurses, licensed professional nurses, certified nurse's aides, and unit clerks; and

(b) Routine nursing supplies; and

(c) Nursing administration; and

(d) Direct portion of medicaid related ancillary services; and

(e) Social services; and

(f) Raw food; and

(g) Employee benefits associated with the direct salaries.

(7) "Director" means the director of the department of health and welfare or the director's designee.

(8) "Equity" means the new book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles.

9. "Facility" means an entity which contracts with the director to provide services to recipients in a structure owned, controlled, or otherwise operated by such entity, and which entity is responsible for operational decisions. In conjunction with the use of the term "facility"

(a) "Free-standing intermediate care" means an intermediate care facility, as defined in and licensed under chapter 13, title 39, Idaho Code, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in section 39-1301(a), Idaho Code; and

(b) "Free-standing skilled care" means a skilled nursing facility, as defined in and licensed under chapter 13, title 39, Idaho Code, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in section 39-1301(a), Idaho Code; and

(c) "Free-standing special care" means a facility that provides either intermediate care, or skilled care, or intermediate care for the mentally retarded, or any combination of either, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in section 39-1301(a), Idaho Code; and

(d) "Hospital-based" means a skilled nursing or intermediate care facility, as defined in and licensed under chapter 13, title 39, Idaho Code, which is owned, managed, or operated by, or is otherwise a part of a hospital, as defined in section 39-1301(a), Idaho Code.

(10) "Forced sale" is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order.

(11) "Goodwill" means the amount paid by the purchaser that exceeds the net tangible assets received. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is nonallowable, nonreimbursable expense.

(12) "Historical cost" means the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architect's fees, and engineering studies.

(13) "Indirect care costs" consists of the following costs either directly coded to the nursing facility or allocated to the nursing facility through the medicare step-down process

(a) Administrative and general care cost; and
(b) Activities; and
(c) Central services and supplies; and
(d) Laundry and linen; and
(e) Dietary (non-"raw food" costs); and
(f) Plant operation and maintenance (excluding utilities); and
(g) Medical records; and
(h) Employee benefits associated with the indirect salaries; and
(i) Housekeeping; and
(j) Other costs not included in direct care costs or costs exempt from cost limits.

(14) "Interest rate limitation" means that the interest rate allowed for working capital loans and for loans for major movable equipment for intermediate care facilities for the mentally retarded shall be the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (1%) at the date the loan is made. All interest expense greater than the amount derived by using the limitation above shall be nonreimbursable; provided, however, that this interest rate limitation shall not be imposed against loans or leases which were made prior to July 1, 1984. Said loans or leases shall be subject to the tests of reasonableness, relationship to patient care and necessity.

(15) "Intermediate care facility for the mentally retarded" means an habilitative facility designed and operated to meet the educational, training, habilitative and intermittent medical needs of the developmentally disabled.

(16) "Major movable equipment" means such item; as accounting machines, beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are

(a) A relatively fixed location in the building;

(b) Capable of being moved, as distinguished from building equipment;

(c) A unit cost sufficient to justify ledger control;

(d) Sufficient size and identity to make control feasible by means of identification tags; and

(e) A minimum life of approximately three (3) years.

(17)"Medicaid" means the 1965 amendments to the social security act (P.L. 89-97), as amended

(18) "Minor movable equipment" includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. The general characteristics of this equipment are

(a) In general, no fixed location and subject to use by various departments of the provider's facility;

(b) Comparatively small in size and unit cost;

(c) Subject to inventory control;

(d) Fairly large quantity in use; and

(e) Generally, a useful life of approximately three (3) years or less.

(19) "Net book value" means the historical cost of an asset, less accumulated depreciation.

(20) "Normalized per them costs" refers to direct care costs that have been adjusted based on the facility's case mix index for purposes of making the per them costs comparable among facilities. Normalized per diem costs are calculated by dividing the facility's direct care per them costs by its facility-wide case mix index, and multiplying the result by the statewide average case mix index.

(21) "Nursing facility inflation rate" means the most specific skilled nursing facility inflation rate applicable to Idaho established by data resources, inc., or its successor. If a state or regional index has not been implemented, the national index shall be used.

(22) "Patient-day" means a calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3 00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care shall be deemed to exist.

(23) "Property costs" means the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal.

(24) "Raw food" means food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions.

(25) "Reasonable property insurance" means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year shall not be considered reasonable.

(26) "Recipient" means an individual determined eligible by the director for the services provided in the state plan for medicaid.

(27) "Rural hospital-based nursing facilities" are those hospital-based nursing facilities not located within a metropolitan statistical area (MSA) as defined by the United States bureau of the census.

(28) "Urban hospital-based nursing facilities" are those hospital-based nursing facilities located within a metropolitan statistical area (MSA) as defined by the United States bureau of the census.

(29) "Utilities" means all expenses for heat, electricity, water and sewer.

56-102. PRINCIPLES OF PROSPECTIVE RATES AND PAYMENT. The following principles shall apply to the reimbursement of freestanding skilled care and hospital-based skilled care facilities

(1) Payments to facilities shall be through a prospective cost-based system which includes facility-specific case mix adjustments. Details of the methodology shall be set forth in rules based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state associations(s) representing hospital-based skilled care facilities. In no event shall reimbursement to any facility exceed the usual and customary charges made to private pay patients; and

(2) Each skilled care facility's case mix index shall be calculated quarterly and rates shall be adjusted based on the case mix of that facility's medicaid residents as of a certain date during the preceding quarter specified in rule; and

(3) In state fiscal year 2000, the total amount paid to skilled care facilities shall approximate the same amount in medicaid expenditures as would have been paid using the methodology in effect in state fiscal year 1999, and the percentages of medicaid funds projected to be paid to freestanding skilled care facilities and hospital-based skilled care facilities shall be the same percentages that are projected to be paid using the methodology in effect during state fiscal year 1999; and

(4) The cost limits used for the direct care and indirect care costs of rural hospital-based skilled care facilities shall be higher than the cost limits used for the direct care and indirect care costs of freestanding skilled care and urban hospital-based skilled care facilities; and

(5) In computing the direct care per diem rate neither medicaid-related ancillary services nor raw food shall be case-mix adjusted; and

(6) Property costs shall not be subject to a cost limitation or incentive. Property costs of freestanding skilled care facilities shall be reimbursed as described in section 56-108, Idaho Code, and property costs of urban and rural hospital-based skilled care facilities shall be reimbursed as described in section 56-120, Idaho Code; and

(7) Cost limits shall apply to direct care costs and indirect care costs. The cost limits shall be based on percentages above the bed-weighted median of the combined costs of both freestanding skilled care and hospital-based care facilities; and

(8) Costs exempt from cost limits are property taxes, property insurance, and costs related to new legal mandates as defined by rule; and

(9) An incentive payment shall be paid to those facilities with indirect per diem costs that are less than the established indirect care cost limit. The incentive payment is calculated by taking the difference between the cost limits and the provider's per them indirect care cost times the incentive percentage. Freestanding skilled care and hospital-based skilled care facilities shall receive the same percentage incentive payments for indirect care costs but no incentive payment for direct care costs. The percentage at which the incentive payment will be set shall be based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing hospital-based skilled care facilities; and

(10) A newly constructed facility shall be reimbursed at the median rate for skilled care facilities of that type (freestanding or hospital-based) for the first three (3) full years of operation; and

(11) A facility adding new beds will have its rates for the three (3) full years following the addition of the beds subjected to an additional reimbursement limitation. This limitation will apply beginning with the first rate setting period which uses a cost report that includes the date when the beds were added. The facility's rate will be limited to the bed-weighted average of two (2) rates the facility's rate in effect immediately prior to the rate first subject to the limitation and the median rate for skilled care facilities of that type (freestanding or hospital-based) at the time the beds were added; and

(12) A facility acquired prior to the end of that facility's fiscal year will be reimbursed at the rate then in effect for that facility until the next cost report can be used for rate setting. If the department determines that the facility is operationally or financially unstable, the department may negotiate a reimbursement rate different than the rate then in effect for that facility; and

(13) If the department determines that a facility is located in an under-served area, or addresses an underserved need, the department may negotiate a reimbursement rate different than the rate then in effect for that facility; and

(14) From July 1, 1999, through June 30, 2002, the nursing facility inflation rate plus one percent (1%) per year shall be added to the costs reported in a facility's cost report for purposes of setting that facility's rate. The inflation rate to be used effective July 1, 2002, and the period of its use will be based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing hospital-based skilled care facilities; and

(15) To control the growth in the cost limits, the increase in the cost limits shall not exceed the skilled nursing facility inflation rate established by data resources, inc., or its successor, plus two percent (2%) per year for the period from July 1, 1999, through June 30, 2002. The maximum rate of growth in the cost limits to be used effective July 1, 2002, and the period of its use will be based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing hospital-based skilled care and

(16) To control declines in the cost limits, the cost limits for the period from July 1, 1999, through June 30, 2002, shall not be lower than the respective cost limits effective July 1, 1999. The minimum cost limits to be used effective July 1, 2002, and the period of its use will be based on negotiations between the department, the state associations representing freestanding skilled care facilities, and the state association(s) representing hospital-based skilled care facilities; and

(17) Rates shall be rebased annually. Rate setting shall be prospective with new rates effective July I of each year, using the principles applying to skilled care facilities set forth in this chapter and the rules promulgated pursuant to this chapter. There will be no settlement between actual costs incurred during the rate year and the rate itself. Rates will be established using the most recent audited cost report trended forward to the rate year. Rates for skilled care facilities with unaudited cost reports will be interim rates established by the department until a rate is calculated based on an audited cost report. The draft audit of a cost report submitted by a facility shall be issued by the department no later than five (5) months from the date all information required for completion of the audit is filed with the department; and

(18) Changes of more than fifty cents (50) per patient day in allowable costs resulting from federal or state law or rule changes shall be treated as costs separate from the cost limitations until such time as they become part of the data used for calculating the cost limits and in cost reports used for rate setting; and

(19) If a review of the data submitted by a facility reveals errors that result in an incorrect case mix index, the department may retroactively adjust the facility's rate and pay the facility any amount by which the facility was underpaid or recoup from the facility any amount by which the facility was overpaid; and

(20) The rates established under the principles set forth in this sect ion shall be phased in using a combination of the reimbursement methodology in effect as of state fiscal year 1999 and the principles set forth in this section and in rules based on negotiations between the department, the state association(s) representing freestanding skilled care facilities, and the state association(s) representing hospital-based skilled care facilities. Effective July 1, 2001, the phase-in provisions will no longer apply and the department shall pay rates solely based on the principles set forth in this section and the applicable rules.

56-108. PROPERTY REIMBURSEMENT -- FACILITIES WILL BE PAID A PROPERTY RENTAL RATE, PROPERTY TAXES AND REASONABLE PROPERTY INSURANCE. The provisions of this section shall not apply to hospital-based facilities which are subject to the provisions of section 56-120, Idaho Code, or to intermediate care facilities for the mentally retarded which are subject to the provisions of section 56-113, Idaho Code. The provisions of this section are applicable to all other facilities. The property rental rate includes compensation for major movable equipment but not for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. Prior to final audit, the director shall determine an interim rate that approximates the property rental rate. The property rental rate shall be determined as follows

(1) Except as determined pursuant to this section

$$\text{Property rental rate} = (\text{"Property base"}) \times (\text{"Change in building costs"}) \times \frac{(40 - \text{"Age of facility"})}{40}$$

where

(a) "Property base" = $9.24 for all facilities.

(b) "Change in building costs" = 1.0 from April 1, 1985, through December 31, 1985. Thereafter "Change in building costs" will be adjusted for each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as of September of the prior year, published by the Marshall Swift Valuation Service. However, for freestanding skilled care facilities "change in building costs" = 1.145 from July 1, 1991, through December 31, 1991. Thereafter, change in building costs for freestanding skilled care facilities will be adjusted each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as of September of the prior year as published by the Marshall Swift Valuation Service or the consumer price index for renter's costs available in September of the prior year, whichever is greater.

(c) "Age of facility" = the director shall determine the effective age, in years, of the facility by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof shall be assigned an age of more than thirty (30) years. However, beginning July 1, 1991, for freestanding skilled care facilities, "age of facility" will be a revised age which is the lesser of the age established under other provisions of this section or the age which most closely yields the rate allowable to existing facilities as of June 30, 1991, under subsection (1) of this section. This revised age shall not increase over time.

(i) If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the director shall set the effective age at thirty (30) years. Adequate documentation shall include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contracts, and original notes of indebtedness. The director shall compute an appropriate age for facilities when documentation is provided to reflect expenditures for building expansion or remodeling prior to the effective date of this section. The computation shall decrease the age of a facility by an amount consistent with the expenditure and the square footage impacted and shall be calculated as follows

1. Determine, according to indexes published by the Marshall Swift Valuation Service, the construction cost per square foot of an average class D convalescent hospital in the western region for the year in which the expansion or renovation was completed.
2. Multiply the total square footage of the building following the expansion or renovation by the cost per square foot to establish the estimated replacement cost of the building at that time.
3. The age of the building at the time of construction shall be multiplied by the quotient of total actual renovation or remodeling costs divided by replacement cost. If this number is equal to or greater than 2.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number. In no case will the age be less than zero.